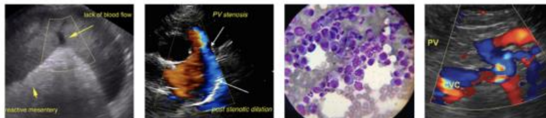

PATIENT

Little Man Elmore

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered Male

AGE

2012

WEIGHT

20 lbs

INTERPRETED BY

Andrea Nicastro,
DVM, Diplomate ACVIM
(*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Andrea Nicastro,
DVM, Diplomate ACVIM
(*Small Animal Internal Medicine*)

HOSPITAL NAME

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REFERRING VET

Dr. Elizabeth Fuller

INVOICE

11005

DATE

6/2/22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Dental performed on 5/20/22. Dog has been lethargic, inappetent for the past 4-5 days with a painful abdomen. Basic chem panel performed 5/31 unremarkable aside from slightly elevated sodium (137) and slightly elevated glucose (114). PCV was 50%. Patient has been on IVF and receiving pain control and Entyce. He has been reluctant to urinate (although making urine).

Abnormal lab-work values: Slightly elevated sodium (137), slightly elevated glucose (114).

Current Medications: cerenia, ondansetron, entyce, buprenex

Radiographic Findings: subjectively small liver, possible peritonitis (possibly consistent with pancreatitis), distended stomach, could not conclusively rule out cranial abdominal mass

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The wall is normal in thickness with a smooth mucosal surface. A moderate amount of suspended echogenic debris is observed within the lumen, along with a small amount of adherent debris. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.78 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

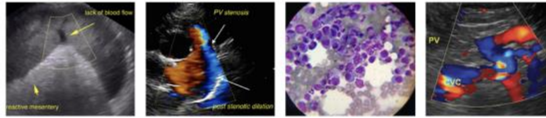
The left kidney is normal size (5.17 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.21 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm at cranial pole) (0.47 cm at caudal pole) (1.85 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.96 cm at cranial pole) (0.54 cm at caudal pole; normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.



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Spleen

The spleen is normal in size (0.85 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively small in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is severely distended with fluid and chyme and is hypomotile. The gastric wall is normal in thickness with a normal layering pattern. The pyloric outflow tract a patent. The duodenum is corrugated in appearance. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The wall of the transverse/proximal descending colon is mildly thickened (up to 0.40 cm) with a normal layering pattern. There is no evidence of an obstructive pattern.

Pancreas

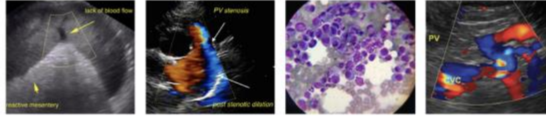
The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and edematous. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is hyperechoic.

Free Abdomen

A moderate amount of echogenic free fluid is present within the abdomen. The mesentery throughout the abdomen is hyperechoic. The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.



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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with moderate to severe acute pancreatitis with secondary peritonitis.
- The duodenal changes are most consistent with hyperperistalsis, secondary to regional inflammation.
- The colonic wall thickening is also likely secondary to adjacent peritonitis.

Secondary Findings

- Subjective microhepatica. This may be a normal variant for this patient or may be secondary to a chronic hepatopathy or a congenital disease (i.e., microvascular dysplasia, portosystemic shunt). Correlation with the patient's liver values is recommended
- Bilateral, minor, chronic renal changes
- Urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.
- Gastric ileus

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma. Consider a promotility agent (i.e., metoclopramide) to address the gastric ileus. If available, hyperbaric oxygen therapy may be useful in reducing pancreatic inflammation. Consider initiation of trickle feeding as soon as the patient will tolerate it, as this may help to maintain enterocyte health.
- Serial monitoring of the patient's bloodwork is recommended to assess deterioration of metabolic functions.
- Serial monitoring (i.e., daily) sonographic monitoring of the pancreas should be considered to assess for the development of abscessation, which can occur in moderate to severe cases of pancreatitis.

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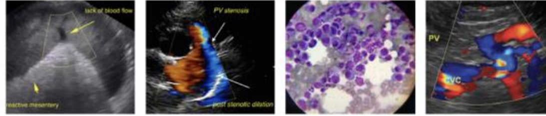

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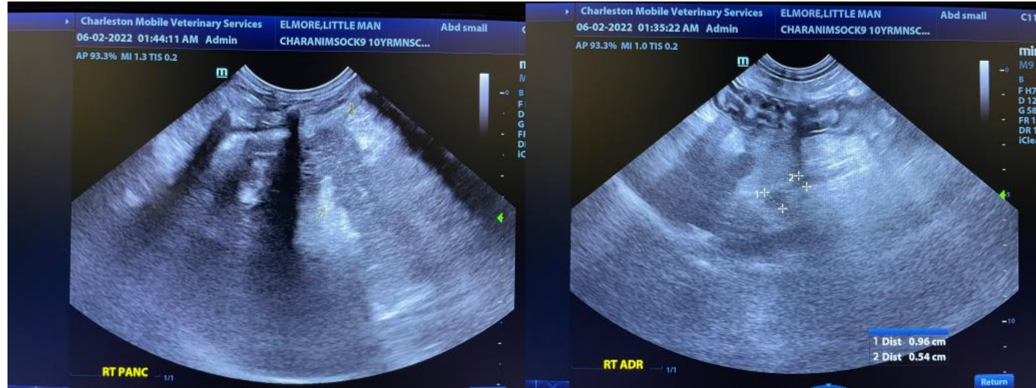

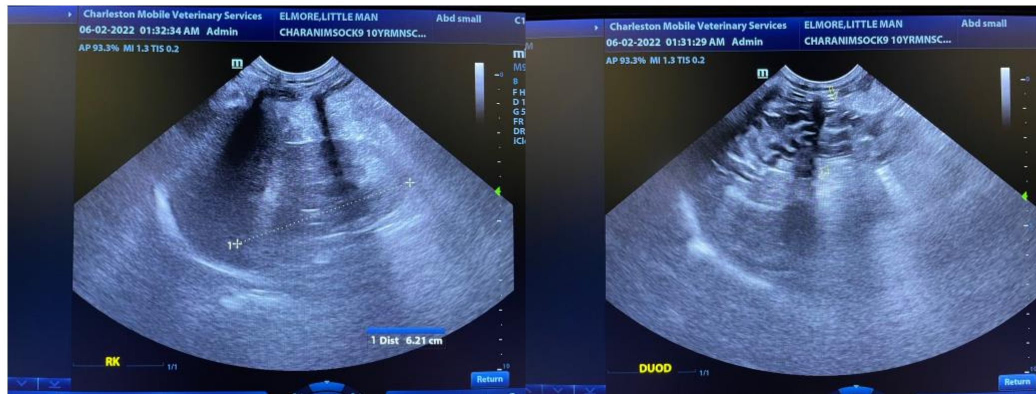

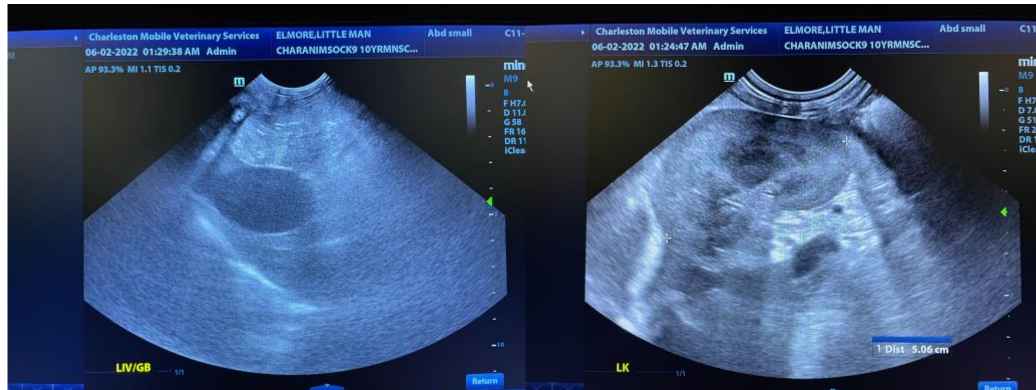

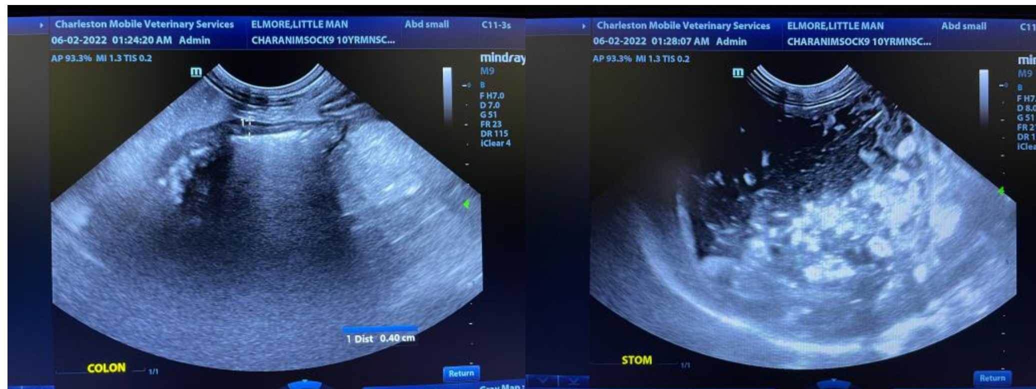

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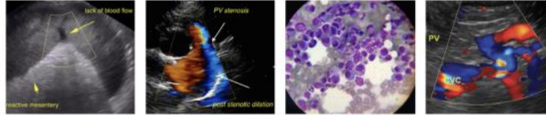

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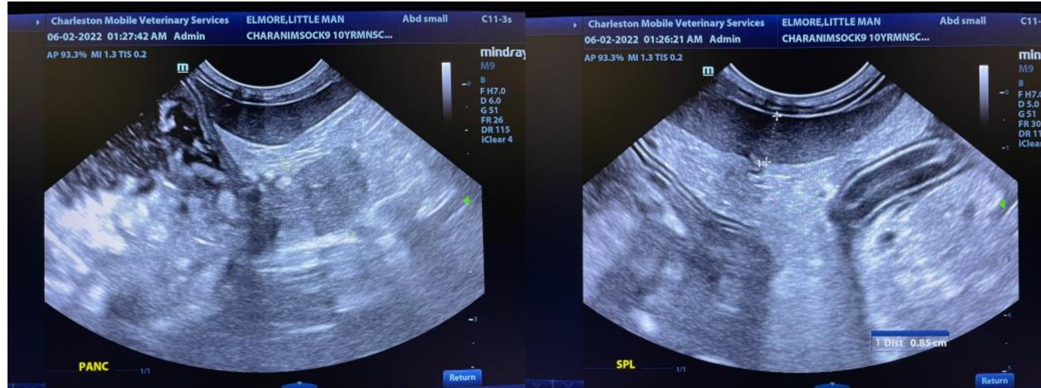

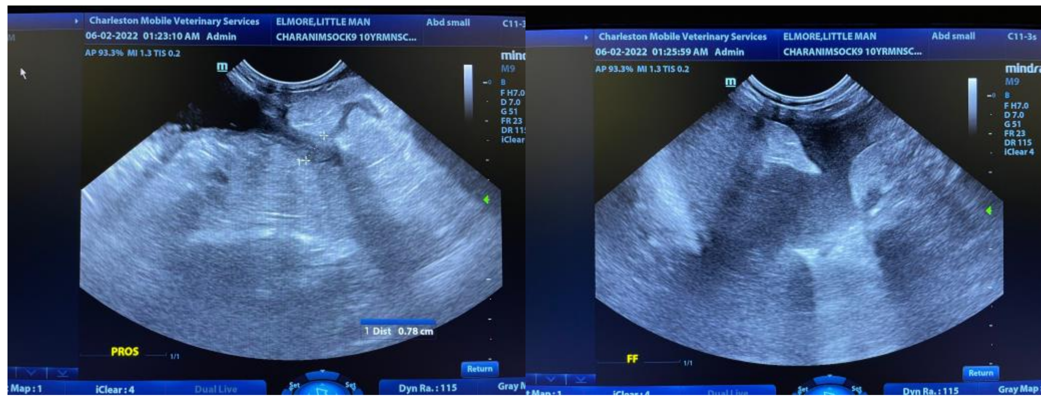

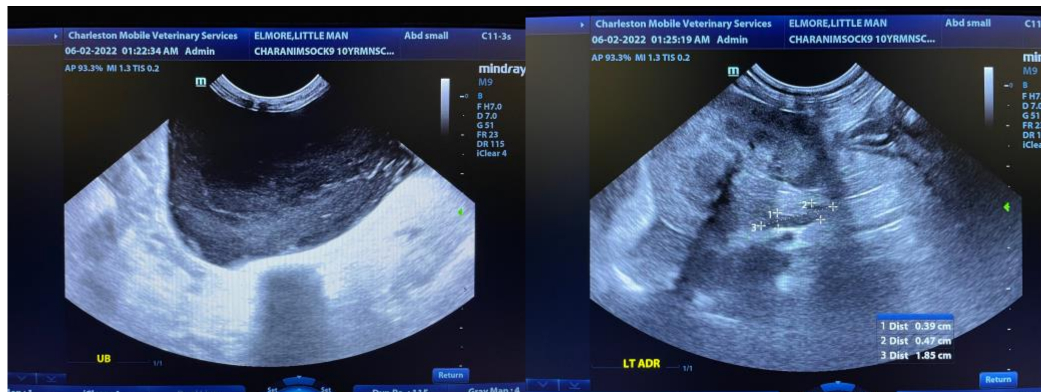

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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